Information Bulletin (08/05)

Auto Insurance Update

from the Office of the Alberta Superintendent of Insurance

effective November 14, 2005

Keeping you informed

A number of issues are currently under consideration as a result of the efforts of two key stakeholder working groups - the Implementation Working Group and the Protocol Review and Evaluation Working Group.

As part of our ongoing review of the process and requirements for diagnosing, treating and making claims under automobile insurance regulations, this Information Bulletin highlights important changes and reminders.

Claim Forms

Form	Changes and reminders
AB-1 Notice of loss and proof of claim	**Important reminders:** • Practitioners should not complete or submit the Notice of Loss & Proof of Claim form (AB-1). There is no fee for completing this form. • This form must be completed and submitted by clients within ten business days of their motor vehicle collision. Please inform clients of this requirement.
AB-2 Treatment Plan	**Important reminders:** • Physicians should not complete the Treatment Plan form (AB-2) unless they are providing "hands-on" treatment, or choose to actively coordinate the care and treatment visits of the client. • If physicians or other health care practitioners (HCP) refer a client for treatment, it is important for the referring practitioners to advise whether or not they have completed the AB-2 form. They should provide a copy to the other practitioners for their reference if one is completed. • The primary health care practitioner (the physician, chiropractor or physical therapist who completes the AB-2 form and is actively coordinating the care and treatment visits of the client) must be explicit as to the treatment method(s), as only the treatment prescribed on the AB-2 form is pre-authorized for payment. • If the insurer has already paid a health care practitioner for completion of the AB-2 form, the insurer is not obliged to pay for a second AB-2 form. • Practitioners are reminded that the AB-2 form should be completed and submitted to the insurer within ten business days of the first assessment of the client. • Copies of the AB-2 form should be provided to insurers and the practitioners providing treatment, as well as to the client.

Whiplash Associate Disorder (WAD)

Clarification:

The *Diagnostic and Treatment Protocols Regulation* currently includes injuries to the entire spine within the WAD category. Following advice from the professions, the majority opinion is that WAD injuries should include injuries only to the cervical spine. Sprain and strain injuries to other areas of the spine should be considered as a sprain or a strain and should not be categorized as WAD injuries. Regulatory changes are under consideration to support this opinion.

Appendix F of the October 1, 2004 Information Bulletin refers to applicable ICD-10-CA Injury Codes required for the completion of the Treatment Plan (Form AB-2). For your reference injuries of joints and ligaments at neck level are referenced with codes beginning with S13. Injuries of joints and ligaments of the thoracic and lumbar regions of the spine are referenced with codes beginning with S23 and S33 respectively. Injuries of other joints and ligaments are also referenced.

Number of treatment visits

Reminder:

Under the *Diagnostic and Treatment Protocols Regulation*, all clients may receive up to a maximum of 10 or 21 pre-authorized payments for treatment visits, depending on the type of injury. However, it is important to remember that, should this number of treatment visits be insufficient to address the injury, clients can still claim treatment visits covered under other plans. For many clients coverage is available under extended health benefits (e.g., Blue Cross or similar employee benefit plans) or from the client's automobile insurer under Section B of the Standard Automobile Policy (SPF No.1). The SPF No.1 is available at: www.finance.gov.ab.ca/publications/insurance.

Treatment Visits and Related Fees: 3 of 10 or 7 of 21 Treatment Visits

Notice:

With respect to practitioner fees for client treatment visits, fees will be applied according to how many treatment visits, with all practitioners, a client has already attended. This clarifies which regulated fee amount Physical Therapists may charge when treating a client (as described in Information Bulletin 03/05).

A Physical Therapist may charge $70 for a treatment visit if the visit is a client's first, second or third (including all other permitted practitioner visits experienced) of the maximum of ten preauthorized, or if the visit is a client's first, second, third, fourth, fifth, sixth, or seventh (including all other practitioner visits experienced) of the maximum of 21 preauthorized, depending on the type of injury.

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Treatment Visits and Related Fees: 3 of 10 or 7 of 21 Treatment Visits continued

Notice:

If the client has already attended 3 (of a maximum 10 preauthorized) or 7 (of a maximum 21 preauthorized) treatment visits with any of the permitted practitioners, a Physical Therapist may only charge $35 for any further treatment visits with the client.

The fee for the treatment visit is not applied according to how many treatment visits the Physical Therapist provided to a client, it is applied according to how many treatment visits, with all permitted practitioners, a client has already attended.

Example:

As illustrated in the following example, the client's number of treatment visits attended determines how a health care practitioner's treatment visit fee will apply (as described in Bulletins 01/05, 03/05 and 04/05). Adjunct therapy (including massage therapist or acupuncturist) visits prescribed on the AB-2 form will always count towards a client's number of pre-authorized payments for treatment visits.

For example if a client has been diagnosed with a WAD I injury and may utilize up to a maximum of 10 preauthorized payments for treatment visits.

Treatment Visit 1	**Treatment Visit 2**	**Treatment Visit 3**	**Treatment Visit 4**	**Treatment Visit 5**
Physical Therapist $70	Physical Therapist $70	Massage Therapist $ MT rate	Physical Therapist $35	Chiropractor $32

Health Care Practitioner Scope of Practice

Notice:

Treatments that are within a health care practitioner's scope of practice are subject to that health care practitioner's regulated fee schedule (as described in Information Bulletins 01/05, 03/05 and 04/05). This includes any treatment authorized by the *Diagnostic and Treatment Protocols Regulation*, that the health care practitioner provides himself or herself. The fee for the treatment visit is determined by the fee schedule for that type of practitioner and is dependant on the client's preauthorized treatment visit number (as discussed above).

Extra Billing and Supplies

Reminder:

The treatment visits under the *Diagnostic and Treatment Protocols Regulation* are intended to be free of any financial barriers that might limit clients seeking early, appropriate treatment for their injuries. “Extra” (or balance) billing practices pose a financial barrier as well as stress to a client, therefore practitioners may not extra-bill. This prohibition is set out in section 5(1) of the *Diagnostic and Treatment Protocols Regulation* and Information Bulletins 01/05, 03/05 and 04/05.

The *Diagnostic and Treatment Protocols Regulation* are intended to provide clients with access to supplies required for self-care and are intended to prohibit any financial barriers a client may have to access these potentially necessary items. Provided that items are itemized on the invoice, they assist the client with necessary self-care, and they are reasonably priced they are eligible to be claimed. These supplies are those that a client would utilize, usually in the home, such as exercise balls, tensor bandages, and cold packs. It is not intended to cover a practitioner's overhead expenses or in-clinic consumption items.

This Information Bulletin is provided under the authority of the Insurance Act and relevant regulations. It provides the latest information on changes to the process and requirements for diagnosing, treating, and making claims under the new automobile insurance regulations. This information is subject to change and if there is any inconsistency between this Information Bulletin and the *Insurance Act*, *Diagnostic and Treatment Protocols Regulation* and the *Automobile Accident Insurance Benefits Regulation*, the latter Act and Regulations prevails.

Relevant information about automobile insurance changes are available online at: www.finance.gov.ab.ca/publications/insurance.

If your clients have questions or concerns they are to be directed to their claims adjuster. If you or your client have any further questions about the changes noted in this Information Bulletin or any related insurance issues, please contact the Office of the Superintendent of Insurance.

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- mail at 402 Terrace Building, 9515-107 Street, Edmonton, AB T5K 2C3
- fax at (780) 420-0752
- phone at (780) 427-8322.
- If calling from outside of Edmonton, call 310-0000 and ask to be connected to (780) 427-8322.